

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 12 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

27354

State File No. 3012

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1014 Cherry
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____ 55 years
years, months or days)

3. (a) PRINT FULL NAME Edward Scofield

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased January 10 1864
(Month) (Day) (Year)

8. AGE: Years 77 Months 6 Days 27 If less than one day _____ hr. _____ min.

9. Birthplace Carthage / Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Salesman

11. Industry or business _____

12. Name Bryant Timothy Scofield
13. Birthplace Dewittville / New York
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Anne Collins
15. Birthplace Hope / New York
(City, town, or county) (State or foreign country)

16. (a) Informant Ralph E. Scofield
(b) Address 512 Law Bldg., K. C., Mo.

17. (a) Burial (b) Date thereof Aug. 9, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Floral Hills Steinbacher

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) 8/9/41 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1014 Cherry
(If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 7
year 1941 hour 6 minute 50 P.M.

21. I hereby certify that I am _____ of the deceased from _____
to _____
that I last saw _____ alive on _____
and that death occurred on the date and hour stated above.
Immediate cause of death _____ Duration _____

Homocysteinemia
Rupture of the heart
Acute + Chronic myocardial infarction
Other conditions: _____
(Include pregnancy within 3 months of death)
Acute + Chronic coronary occlusion

Major findings: _____
Of operations _____

Of autopsy 93D
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur on or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Edwin W. Miller (M. D. or other) 3
Address 16 E. P. Ave. Date signed _____

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Park G. Rowe

Licensed Embalmer No. *2347*

P. O. Address.....

J. E. Ma

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.